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Meeting the Challenge:

Ending Treatment Disparities for Women of Color

A Background Paper

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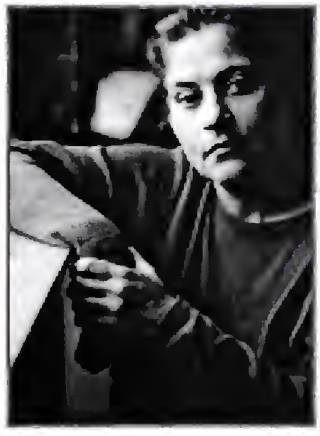

Meeting the Challenge:

Ending Treatment Disparities for Women of Color

A Background Paper

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Special thanks to NMHA's Working Group on Substance Abuse/Addiction and Paula Heim of the MHA of Hawaii for their input and feedback in the development of this document.

This document was developed by the National Mental Health Association as part of the Targeted Technical Assistance project of the National Association of State Mental Health Program Directors (NASMHPD) and the Division of State and Community Systems Development (Mental Health Block Grant) of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

National Mental Health Association

NASMHPD

CMHS

SAMHSA
Substance Abuse & Mental Health Services Administration

Table of Contents

I. Introduction 1

II. Background Information 1

- Mental Health Disorders In Minority Populations 1
- Mental Health Disorders In Women and Women of Color 3
- Substance Abuse/Addiction Issues for Women and Women of Color 4
- Co-occurring Mental Health and Substance Abuse/Addiction Disorders 6

III. Stigma 7

- Stigma and Women 7
- Criminal Justice Issues 8
- Related Health Issues 8

IV. Service Delivery and Treatment Program Issues 9

- Societal and Environmental Risk Factors for Women of Color 9
- The Critical Need to Address Diversity 9
- Ethnic, Cultural and Language Issues 10
- Need for a Safe Treatment Environment 10
- Access to Child Care 11
- Support Services for Children and Family 11
- Economic Issues 12
- Access to Safe Housing 12
- Access to Transportation 12
- Access to Health Care 13

V. Action Steps 13

- Community Call to Action 14

VI. Bibliography 15

I. Introduction

Research clearly shows that women are more likely than men to experience co-occurring mental health and substance abuse/addiction disorders (NIDA, 1998), thus women have an increased need for comprehensive treatment models. Because the majority of persons who suffer from addictive disorders, and hence those who seek treatment for substance abuse/addiction and co-occurring mental disorders are male and white, women of minority status are often unaware of, or unable to access, appropriate services. When women of color who have mental health problems, substance abuse/addiction and co-occurring disorders do seek help, they can encounter inadequate and irrelevant treatment programs with little or no sensitivities to specific gender, racial and cultural issues, such as childcare and family support services. Additionally, many treatment programs do not provide services that support a woman's ability to recover successfully in the community, such as appropriate job skills training, transportation and affordable housing.

The National Mental Health Association (NMHA) believes that it is essential for community leaders and mental health and substance abuse/addiction stakeholders and treatment providers to work across systems, races and cultures to develop pathways for women of color to access services reflective of, and responsive to, their needs and experiences. Cultural background plays a large role in how the symptoms of mental illness and substance abuse/addiction develop, are reported and interpreted, and consequently, if and how they are treated. Women of color are apt to have less access to routine medical care where early diagnosis and intervention can be done, so their mental health and substance abuse/addiction problems are often more developed and complicated, and their social supports more depleted when they do try to access treatment. Cultural identity and cultural sensitivity issues are complex and cannot be isolated from other factors that may either draw a woman of color into treatment or cause her to leave treatment (Jones et al, 1997). Culturally sensitive social service practice is believed to increase mutual communication, utilization of services, compliance, treatment effectiveness and consumer satisfaction (Wright & Donoghue, 1997).

Siloed funding, fragmented services and lack of understanding of the treatment needs of women of color create barriers to recovery. NMHA challenges advocates, families and service providers in communities to listen to the voices of these women and provide service coordination and appropriate funding to meet their needs. This background paper provides research-based information, strategies and action steps for grant writing and other funding, advocacy, coalition building, community services assessments and program development.

Now is the time to open the doors for healing to women of color. This process takes commitment, persistence and leadership in each community, and must be guided at all stages by the voices of the women served, and not served, by the system. When these women can heal, and when their families can heal, only then can their communities heal.

II. Background Information

Mental Health Disorders In Minority Populations:

According to *Mental Health: A Report of the Surgeon General*, the U.S. mental health system is not well equipped to meet the needs of racial and ethnic minority populations, making these populations underserved. The report also states that if members of these groups succeed in accessing services, the treatment may be inappropriate to meet their needs. Without

culturally competent services, this problem will only worsen because of the anticipated growth of minority populations (DHHS, 2000).

Depression, in particular, has often been misdiagnosed in communities of color because of cultural barriers such as language, trust and values in the relationship between doctor and patient, and reliance on the support of family and the religious community rather than mental health professionals during periods of emotional distress. Many individuals in minority cultures "mask" depressive symptoms with other medical conditions, somatic complaints, substance abuse/addiction and other psychiatric illnesses. Socioeconomic factors that contribute to misdiagnosis and inadequate care include limited access to medical care, and a mistrust of medical health professionals based in part on historical higher-than-average institutionalization for members of minority groups with mental illness (NMHA, 2000-B).

According to Mental Health: A Report of the Surgeon General, *the U.S. mental health system is not well equipped to meet the needs of racial and ethnic minority populations, making these populations underserved.*

The prevalence of mental disorders is estimated to be higher among African Americans than among whites, most likely due to socioeconomic differences. They are under-represented in some private outpatient populations, over-represented in inpatient populations and more likely than whites to use the emergency room for mental health treatment (DHHS, 2000). Numerous studies confirm that African Americans drop out of services at a significantly higher rate than whites and use fewer treatment sessions for mental health services. They enter treatment at a later, more advanced stage than whites, under-consume community mental heath services of all kinds, are misdiagnosed more often than whites, and are more often diagnosed with a severe mental illness than whites (WICHE, 1996).

The prevailing attitudes of a racial or ethnic group can greatly influence their access to and participation in services. According to an NMHA survey on attitudes and beliefs about depression in the African-American community, approximately 63 percent of African Americans believe that depression is a "personal weakness," compared to the overall survey average of 54 percent. Only 31 percent of African Americans said they believed depression is a "health" problem, and nearly 30 percent of African Americans said they would "handle it" themselves if they were depressed, while nearly 20 percent said they would seek help for depression from friends and family. Only one in four African Americans recognize that a change in eating habits and sleeping patterns are signs of depression; only 16 percent recognize irritability as a sign. Only one-third of African Americans said they would take medication for depression, if prescribed by a doctor, compared to 69 percent of the general population. Almost two-thirds of respondents said they believe prayer and faith alone will successfully treat depression "almost all of the time" or "some of the time" (NMHA, 2000-B).

Asian Americans have higher rates of depression than traditionally believed (NIMH, 2000). Many Asian Americans attach stigma to mental disorders because they think that revealing problems or dealing with problems by seeking professional help are signs of personal immaturity, weakness and a lack of self-discipline. They are apprehensive about the reaction of their families to the fact they are seeking help. Some research indicates Asian Americans often somatize mental health problems to avoid shame and maintain the honor of the family (Uba, 1994). These and other cultural factors may cause this group to seek

treatment from a community or religious leader rather than a mental health professional.

There are specific spiritual and cultural relationships that must be taken into consideration in working with the Hawaiian and Pacific Islander communities. Mental illness is often seen as a spiritual experience, a communication from a relative who has passed on, or a result of some misdeed. Substance abuse/addiction and suicide rates are increasing, due to generally lower socio-economic and educational achievement and lack of culturally sensitive service providers. Co-occurrence and exacerbation of physical health problems like hypertension, diabetes and obesity are similar to rates found in the American Indian population (Uba, 1994).

Research suggests that the majority of women suffering from substance abuse/ addiction and mental health problems have been victims of rape, incest or physical and emotional abuse.

Within the American Indian (AI) population, there are over 400 separate tribes, each of which has its own cultural and social norms. Depression is also a significant problem in American Indian communities. Alcohol abuse and dependence are approximately double the rates found in other population groups, and suicides occur at "alarmingly high levels" (DHHS, 2000).

Mental Health Disorders In Women and Women of Color:

Approximately 12 million women in the United States experience clinical depression each year (NIMH, 1999-A). About one in every eight women can expect to develop clinical depression during their lifetime, roughly twice the rate of men (NIMH, 1999-A/B). Depression occurs most frequently in women aged 25 to 44, prime child-bearing years, and is misdiagnosed approximately 30 to 50 percent of the time (NIMH, 1994, 1999-B). Research shows that between one-third and one half of depressed people also suffer from some form of substance abuse/addiction or dependence (NIMH, 1999-C). Women who are depressed are more likely to become alcoholic than their male counterparts (McGrath et.al., 1995).

Many factors in women may contribute to depression, such as developmental, reproductive, hormonal, genetic and other biological differences. Social factors may also lead to higher rates of clinical depression among women, including stress from work, family responsibilities, the roles and expectations of women and increased rates of sexual abuse and poverty (NIMH, 1995).

Research suggests that the majority of women suffering from substance abuse/addiction and mental health problems have been victims of rape, incest or physical and emotional abuse (Grella, 1996). The life-long psychological and emotional impact of sexual abuse has important implications for treatment and recovery in women with co-occurring disorders. Trauma survivors frequently experience chronic depression and anxiety. Post Traumatic Stress Disorder (PTSD) is the most common anxiety disorder in women and often develops as a result of sexual trauma and abuse. Women with PTSD commonly experience states of both hyper-arousal and dissociation, and substance abuse/addiction can become a form of self-medication that mitigates symptoms of fear, anxiety and depression in survivors of trauma.

Some evidence suggests that women and minorities are most likely to have depression and PTSD (Leshner, 1999), which makes understanding the link between PTSD and

substance abuse/addiction critical in the treatment of women. Substance use disorders have been linked with a host of other risk factors among women, including involvement in criminal acts to obtain drugs (e.g., larceny or prostitution) and participation in high-risk sexual behavior. Similarly, many interpersonal and social conflicts stem from substance use and its associated physical and mental health problems, including instability in relationships, unwanted or early pregnancy, failed educational pursuits and diminished educational achievement, impoverished occupational performance, jeopardized access to employment opportunities, restricted social integration and lifestyle behaviors that affect physical health and emotional well-being (NIDA, 1998).

Females with severe mental illness (SMI) frequently experience conflict and stress in their intimate relationships. Studies indicate higher rates of sexual activity, marriage, divorce, and parenthood among females with SMI compared to their male counterparts. Females with SMI are more likely to choose a spouse with mental illness, which can result in heightened marital conflict and exacerbated symptoms. It is important for treatment programs to address issues surrounding relationships and sexuality as they relate to the lives of women with mental illness.

Substance Abuse/Addiction Issues For Women and Women of Color:

Substance abuse and addiction are among the most critical health and social problems facing the people of the United States today. The use, misuse and abuse of alcohol and other drugs, including tobacco, are responsible for more than one in four preventable deaths each year, and costs to the economy was estimated to be about $246 billion for 1992. While whites consistently use the majority of alcohol and drugs, there are consistent use that needs to be addressed among minorities, including minority women. The 1998 National Household Survey on Drug Abuse estimates past month use of any illicit drug by 4.5 percent of Hispanic/Latina females and 5.2 percent of African American females (SAMHSA, 1999).

Compared to other ethnic groups, Hispanics/ Latinas come in second highest in use of alcohol, binge drinking and heavy alcohol use. In the general Hispanic/Latino community, the main substance used is alcohol; the two main illegal drugs used are marijuana and cocaine. Hispanic/Latino families living in poverty are at greater risk for having problems with substance use, and tend to keep substance use problems a 'secret' within the family. Hispanic/Latina females use illegal drugs at a younger age than males, and often get involved with alcohol and drug use as a way to be 'supportive' of their partner who is using alcohol and drugs. In at least one study, six out of 10 Hispanic/Latina pregnant adolescents report drinking before their third month of pregnancy, and half report smoking marijuana (SAMHSA/CMHS, 1999).

Alcohol is the primary drug of choice among American Indians. While they represent a small percentage of the total US population, their age-adjusted alcohol-related mortality rate is 5.3

times higher than that of the general US population (Walker, et al, 1996). American Indians use and abuse alcohol and other drugs in combination, at a younger age and at higher rates than other groups (SAMHSA/CSAT, 1999). Socioeconomic factors including high unemployment rates and low educational achievement have been used to explain the increased prevalence among this population. Researchers have also suggested that American Indians may be genetically predisposed to alcoholism (Beauvais, 1998).

AI women tend to die at higher rates than other women due to alcohol involved causes. They also have higher rates of co-occurring disorders than their male counterparts. Physical abuse plays a significant role in the development of substance abuse/addiction problems (SAMHSA/CSAT, 1999). Though there is very scant research on American Indians and mental health and substance abuse/addiction prevention and treatment issues, preliminary studies point to a high incidence of co-occurring mental health and substance abuse/addiction problems, including anxiety, depression and suicide (Walker, et al, 1996; WICHE, 1996).

Asian Americans and Pacific Islanders' alcohol and substance abuse/addiction rates vary considerably among subgroups and are influenced by socioeconomic variables including income, educational achievement, and family cohesiveness. Although alcohol and substance abuse/addiction rates are low among female Asian Americans and Pacific Islanders, they are at increased risk for developing co-occurring mental and physical disorders since they often serve as primary caretakers while supporting their families financially (CSAT, 1999). Often cultural expectations can serve as barriers to treatment. In certain social situations, use of alcohol and mood-altering drugs is seen as culturally acceptable and a necessary aspect of bonding and affiliation (CSAP, 1998).

It is noted throughout the literature that there is severe lack of research on the treatment needs of women, the effects of new treatment on women, and clinical trials for the development of new medications on women (NIDA, 1998; Greenberger, 1998). What is known is that women develop alcohol and drug-related complications, such as liver and heart diseases much more quickly, and after consuming much less of the drug, than men (NIAAA, 2000).

Minority women tend to initiate alcohol and other drug use at younger ages than non-minority women — a factor that has important implications for prevention efforts.

Minority women tend to initiate alcohol and other drug use at younger ages than non-minority women — a factor that has important implications for prevention efforts. In addition, they often use drugs in groups of friends, creating a network of dependence that can be difficult to disengage from. Socioeconomic factors have been linked to differences in substance abuse/addiction patterns within different minority groups.

Nicotine dependence is now the most common psychiatric diagnosis in the United States and the number one cause of preventable death and is rising among females (Bergen & Caporaso, 1999). Factors that have been associated with cigarette use include low socio-economic status, divorce or separation, and the presence of a mental illness (SAMHSA, 1997). Young women between the ages of 18-25 are at the greatest risk for smoking. Among all females, smoking rates are lowest among Hispanic/Latina and Asian/Pacific Islanders and highest in Caucasian and African American women.

Lung cancer is now the leading cause of cancer death for women. According to the recently

released *Women and Smoking: A Report of the Surgeon General - 2001*, socio-economic variables including level of education, income, and neighborhood factors put women of color, who are over-represented in lower SES groups, at significant risk for smoking. Smoking prevalence today is nearly three times higher for women who only have 9-11 years of education (32.9 percent) than among women with 16 or more years of education (11.2 percent) (HHS, 2001).

Additionally, women who smoke experience gender-specific health consequences, including increased risk of adverse reproductive outcomes. Studies indicate high rates of co-occurrence between nicotine dependence and depression, anxiety disorders, and other substance abuse/addiction problems (Breslau et. al., 1991). This association is particularly significant for women, who are twice as likely to develop clinical depression and fives times more likely to have an anxiety disorder than men. Smoking cessation efforts in women may be complicated by other factors such as post-cessation weight gain and acute increases in tension, anxiety, and irritability (HHS, 2001).

[I]n any twelve-month period 10 million people in this country will have a combination of at least one mental health and one substance abuse/addiction disorder.

Co-occurring Mental Health and Substance Abuse/Addiction Disorders:

Mental illness and substance abuse/addiction are problems that often occur together, exacerbating and complicating the symptoms and consequences of each disorder, and their treatment. A report from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that in any twelve-month period 10 million people in this country will have a combination of at least one mental health and one substance abuse/addiction disorder.

The prevalence of substance abuse/addiction disorders in patients with severe mental illness is higher than in the general population. While people with schizophrenia do not constitute a large portion of the drug abusing population, an extraordinarily high percentage of people with this disorder abuse drugs (Leshner, 1999).

Studies in the last ten years have demonstrated co-occurrence rates from 29 percent to over 50 percent (Reiger, Farmer, Rae, et. al, 1990; Kessler, 1994). The 1998 National Household Survey on Drug Abuse shows that 52 percent of those with a lifetime history of alcohol abuse or dependence also had a lifetime mental disorder; 59 of those with a lifetime history of drug abuse or dependence had a lifetime mental disorder (SAMHSA, 1999). Three million individuals with co-occurring disorders have at least three disorders; one million have four or more (National Health Policy Forum, 1998).

Some theories suggest that alcohol and drugs are used by a segment of substance abusing population to self-medicate symptoms of mental disorders such as anxiety and depression. Long term substance abuse/addiction, and the stressors of the accompanying lifestyle, i.e., school and work failure, relationship problems, criminal involvement, can also lead to the development of mental health problems.

Women with eating disorders are also at high risk for alcohol and substance abuse/addiction problems. While the disorders have different causes, the presence of one puts an individual at higher risk for developing the other.

Research shows that co-occurring mental health and substance abuse/addiction disorders are correlated with increased risk of relapse in recovery, violence, incarceration, depression,

suicide, homelessness, and HIV/AIDS, and other sexually transmitted and infectious diseases, such as Hepatitis C (Alexander, 1996; Institute of Medicine, 1999). Severely disabled women are especially vulnerable to assault which can exacerbate mental health and substance abuse/addiction problems.
Women of child-bearing age with mental health and substance abuse/addiction disorders face numerous obstacles when attempting to access treatment. Few programs are designed to meet the needs of women with children, or who are pregnant, who have co-occurring disorders. Scientific evaluation of these programs to make them "evidence-based," and thus available for replication with grant monies, are even rarer (Grella, 1996).

No group encounters more stigma, social alienation or difficulty getting basic needs met than persons with mental health and/or substance abuse/addiction who are homeless, especially women with young children.

Because of the prevalence of co-occurring disorders among women who have substance abuse/addiction and mental health disorders, it is critical that service providers be adequately cross-trained and that the gatekeepers of the service systems understand the dynamics of women with co-occurring disorders and assess for them at all points in the treatment process.

III. Stigma

Stigma and Women:

The stigma issues surrounding women of color who have mental health and/or substance abuse/addiction disorders are staggering and complex. This is especially true for women who have been arrested and/or incarcerated, lost one or more jobs, had one or more unsuccessful treatment experiences, or perhaps lost custody of her children as a result of a mental health or drug problem. Poverty, family violence, and lack of adequate housing and job skills add to stigma. Society's judgments may be even harsher toward the drug addicted pregnant woman or woman with children (Grella, 1996). Often the systems that are made to support those with mental heath and substance abuse/addiction problems add to the stigma by blaming the consumer for her illness, or restricting access to care and poorly coordinating care.

No group encounters more stigma, social alienation or difficulty getting basic needs met than persons with mental health and/or substance abuse/addiction who are homeless, especially women with young children. Once homeless, persons with co-occurring disorders require more services and are more likely to remain homeless than other groups of homeless persons (Drake, Yovetich, Bebout, et. al, 1997).

Stigma often prevents people from learning about what services may be available in their community. For this reason, it is vital to increase public awareness about all the issues related to the mental health and treatment needs of women of color. Public education and media messages must be carefully crafted to help reduce stigma and increase treatment options for women of color.

Marketing and outreach for treatment programs need to be designed to attract the attention of the group that need them most. Studies show that special emphasis needs to be placed on outreach to and engagement of women of color at each step through the referral and treatment process (Jones, 1997; Kline, 1996). Outreach needs to be done repeatedly, in many settings, and by people that women of color can identify with and trust.

Criminal Justice Issues:

Incarceration and experiences of trauma, abuse and degradation in the justice system increase stigma. Women of color are over-represented in the justice system, and many are there for minor criminal activity related to substance abuse/addiction, mental illness and co-occurring disorders (Peters & Bartoi, 1997, CSAT, 1999). Women arrested for all crimes have more frequent and more severe addictions than men (Grant & Campbell, 1998). Most of the women entering the criminal justice system are under 40, 80 percent are parents and only 11 percent were arrested for a violent offense (CSAT, 1999). In recent years, many women have received long sentences for non-violent, minor offenses because of repeat offender policies (CSAT, 1999).

Diversion programs for non-violent offenders that include treatment services for women with mental health and substance abuse/addiction problems would reduce the number of women in jails and prisons, and lessen the amount of trauma experienced by women in the criminal justice system.

Successful re-entry into the community from jail or prison is compromised by lack of effective, even basic, treatment programs (SAMHSA/CSAT, 1998). Often the justice system is used as the de-facto treatment program for women (and men) who cannot access treatment services in their communities, and done with little or no aftercare or transition planning. Comprehensive and integrated community-based service systems are needed to help women break the cycle of relapse/ decompensation, arrest and incarceration (GAINS, 1999).

Related Health Issues:

Women are the fastest growing population in the AIDS epidemic (AIA, 1996; Nyamathi, et al, 1997). Substance abusing women of childbearing age have been found in one study to be more than 100 times more likely to be HIV positive than all other women of childbearing age in the United States. According to the National Institute on Drug Abuse, infection with the Hepatitis C Virus (HCV) is a significant issue, intertwined with substance abuse/addiction and HIV-AIDS because injection drug use now accounts for at least 60 percent of HCV transmission in the United States (NIDA, 2000).

The issues regarding HIV/AIDS and HCV are complex and critical for women of color with mental health and substance abuse/addiction problems. They are at growing risk for infection due to relationships with infected partners, shared use of contaminated needles, and trading sex for drugs (AIA, 1996). The economic, psychological and medical consequences of HIV/AIDS are devastating, but the pressing need for drugs and money often take precedence over HIV prevention and health for women who live on the streets (Turner & Solomon, 1996). Their children, both born and unborn, are at increased risk for infection and for losing their mothers to early death (Adnopoz, et al, 1997).

The risk of HIV infection is even higher for persons with co-occurring mental health and substance abuse/addiction disorders. Providing ways for those who are HIV positive to address their physical health issues while in treatment is quite complicated but

crucial, since these women are also at risk for additional medical and mental health disorders, ranging from diabetes to dementia. And, they must confront difficult issues such as confidentiality and access to medication (SAMHSA/CSAT, 2000-B).

HIV/AIDS/HVC education and prevention is critical in all communities, and it must include clear messages targeted toward women of color.

IV. Service Delivery and Treatment Program Issues

Societal and Environmental Risk Factors for Women of Color:

Poverty and economic disadvantage are recognized as risk factors to both mental illness and substance abuse/addiction. According to the National Council of La Raza (NCLR), the poverty rates for Hispanic families, working Hispanic families, and Hispanic children remain disproportionately high (Soles, 2000). Poverty, overcrowding, illiteracy, unemployment, the breakdown of two-parent families, and environmental stressors associated with systemic and interpersonal racism have been repeatedly cited as probable causative factors for substance abuse/addiction in African Americans (SAMHSA/CSAT, 1999).

Poverty and economic disadvantage are recognized as risk factors to both mental illness and substance abuse/addiction.

Institutionalized racism continues to support prejudice and discrimination even among those who are well trained and well-intentioned (Wright & Donoghue, 1997). These biases are known to permeate many systems of the health care and human services fields. Effective programs in inner-city communities should be community-based, family-oriented and multi-generational, since these are the systems that provide the social supports in the African American, Latino, Asian and American Indian cultures.

There is little written specifically about the treatment and prevention of substance abuse and mental health problems of African American, Latina, Asian American and American Indian women, most likely because their data are not captured in the "traditional" settings. Information dissemination from service providers who are working with women of color to the rest of the field is critical to the development of effective programs in communities across the country. And there is an urgent need to find ways to share the stories and experiences of those women who are successfully healing and recovering.

The Critical Need to Address Diversity:

The lack of attention to diversity between and within cultures and races and the absence of culturally competent staff create additional barriers to accessible and effective treatment for women of color. It is critical that treatment programs serving non-English-speaking women have staff who are bi-lingual, and who have a clear understanding of the acculturation process and can address the fears and the needs of immigrant women (Trepper, et.. al, 1997).

Also, in addition to concerns and issues related to gender, race, ethnicity and sexual orientation, it is very important to be sensitive to the life experiences of women who have mental illness and/or are addicted, such as trading sex for drugs or having experiences of domestic and family violence.

Ethnic, Cultural and Language Issues:

The prevention literature consistently reports that ritual in families and communities is a very strong protective factor against drug use and other high-risk behavior (NACoA, 1998). Family relationships are the primary support systems in many minority communities, in ways and configurations quite different from the majority culture. Relationships with family and friends who are not drug users provide very valuable supports for women of color while in treatment (Jones, et al, 1997; Kline, 1996; Argeriou & Daley, 1997). The literature strongly supports the critical place of family, religion/spirituality, and culturally similar role modeling and mentoring as important factors in successful recovery for people of color.

Family relationships are the primary support systems in many minority communities.

Not being able to understand the language, or not feeling as if they can clearly communicate their needs can make women feel frustrated and unwanted, and can create enormous barriers to treatment admission and retention. Having family members, especially children, do translating for a woman while she is speaking of sensitive topics, such as mental illness, sexual history and drug-taking behavior violates family boundaries and cultural taboos, and significantly decreases the likelihood of getting accurate information.

It is crucial that treatment providers receive cultural competency training that promotes awareness and understanding of different racial and ethnic backgrounds, practices and taboos. Successful program participants have identified having treatment plans that included "cultural identity components," such as strong links to healthy immediate and extended family members and faith community, as helpful. Hiring staff that are proficient in a foreign language or that are of the same ethnic group as their clientele is an effective method of improving treatment services.

Need for Safe Treatment Environment:

Women with mental health, substance abuse/addiction and co-occurring disorders are more likely to have experienced childhood physical or sexual abuse (Rach-Beisel, Scott & Dixon, 1999). Women need to have treatment providers who ask about, and make it safe to discuss, incest, sexual and physical abuse and experiences on the street exchanging sex for drugs, without being or feeling re-victimized, intentionally or not. Not only do these women need focused attention to their own trauma issues for their recovery, they are also at increased risk for abusing their children (SAMHSA/CSAT, 2000-A). Important components of effective treatment services for women include teaching skills for safety and empowerment and access to services for sexuality and reproduction (Rach-Beisel, Scott & Dixon, 1999).

Studies reveal that women in coed treatment facilities often experience sexual harassment from their male counterparts (PROTOTYPES, 2000). Traditional treatment models where men and women are in recovery groups together, or where confrontation is a core treatment group value, may trigger memories of prior abusive situations, and be unintentionally damaging to persons who have PTSD (Kline, 1996). The treatment women receive is often so abrasive and blaming that it reinforces their distrust in service providers and decreases their willingness to utilize services (Wright & Donoghue, 1997). Availability of single-sex programs is one proven way for communities to provide safer environments for women to heal and recover.

Access to Child Care:

By far, the largest barrier to accessing treatment for women of child-bearing age is leaving their children in the care of relatives or in the foster care system, for fear of losing permanent custody of their children (Lewis, et al, 1996; Kline, 1996). Until recently, there were few substance abuse/addiction and mental health treatment programs that would take children or pregnant women, as they pose legal liabilities and can be hard to fund. There is an interesting duality that children are the primary source of motivation for treatment for women, yet fears about the safety and care of their children while in treatment are also the primary reason for poor retention rates. One program in Florida found that women who were allowed to bring their children to the program were five times more likely to stay for a year, and stayed about three times longer than women not offered onsite child care and support treatment (CASA, 1996).

Even when residential programs that accommodate women and their children are available, there is seldom childcare available in outpatient settings, which may be the only treatment option in a community. Aftercare and ongoing peer support also depend on being able to balance the demands of recovery and parenting, and little attention is paid to these issues in traditional treatment programs. Additionally, women need parenting education, family therapy, parallel treatment for their children, an opportunity for children to live-in with their mothers while in treatment, and "women only" groups for safety and support regarding sexuality, violence and trauma (PROTOTYPES, 2000).

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Support Services for Children and Family:

Research consistently shows that children of parents with substance abuse/addiction problems and parents with mental illness are at high risk for substance abuse/addiction and mental health problems, and need focused education and support systems (NACoA, 1998). Jail is often a reality for women with substance abuse/addiction problems and over seventy-five percent of all incarcerated women have children (PROTOTYPES, 2000). Support and education services to strengthen family systems and provide support for the children of the women in treatment are critical components of effective treatment programs. There is a strong need for the family to support an individual in the whole process of treatment, from the point of access, through the ups and downs of the treatment and recovery process (Kline, 1996).

The research literature and conventional wisdom both suggest that the family members of persons with substance abuse/addiction and mental health problems who are in treatment should receive support services. School-aged and younger children are viewed as particularly benefiting from such structured programs (NACoA, 1999). Yet, in a survey of substance abuse/addiction treatment programs, the National Association for Children of Alcoholics reported that sixty-nine percent of the treatment providers that responded to the survey indicated that they do not offer services to the school-aged children of their clients (NACoA, 1999). The primary reason given was lack of funding for such services.

The long-term community benefits of providing support services include substance abuse prevention for the other members of the family. Community stakeholders who understand the need to strengthen the family to improve the outcomes of treatment for women should work to secure the funding to provide education and support services for these children.

Economic Issues:

Women of color who are experiencing mental health problems or have serious substance abuse/addiction problems are less likely to be employed than their male counterparts, with unemployment rates estimated as high as 80 percent (CASA, 1996). This means that they have to rely on publicly funded treatment, increasing their chances of being turned away or put on a waiting list. Women of color may be single parents who are supporting their families with poorly paying jobs, no insurance benefits, who are unable to find funds to pay for treatment even when they can find openings in appropriate programs. Economic pressure can create tension among family members that causes them to discourage treatment for the mother, daughter, wife or girlfriend.

Traditional treatment programs have focused on the job-skill and job-readiness needs of men returning from treatment to the workforce.

Several studies indicate that women are less likely to participate in vocational training services and comprise less than one third of the clientele in these programs. Even when women do complete job skills training, they frequently report earning salaries less than 56 percent of those earned by their male counterparts. Staff expectations and the quality of services delivered can appear to be lower for female participants. Therefore, the vocational needs of women, who have a higher probability of having few or no job skills, often do not get addressed. This creates barriers for these women to become self-supporting (Grella, 1996). Without changes in the economic and employment prospects for this group of women, any treatment or prevention efforts will have little long term effect (Cohen, 1999).

Access to Safe Housing:

A very significant risk factor for relapse from recovery from mental health and substance abuse/addiction problems is a return to a recovering individual's former environment, possibly one filled with violence (Wright & Donoghue, 1997), and at least filled with cues and people that "tempt" a return to the former lifestyle, whether it be drug or alcohol abuse, non-compliance with medication or an abusive relationship. Safe, affordable housing with adequate space and facilities for children is a critical need in effective treatment for all women, but especially women of color.

Access to Transportation:

Even in metropolitan areas, access to services may be severely restricted by a lack of efficient and reliable transportation. Many individuals seeking substance abuse/addiction treatment have had their driving privileges revoked, and where public transportation is available, it may not be reliable or time effective, especially when a woman in recovery is trying to balance return to the workplace with parenting and treatment needs (Trepper, et. al, 1997). Locating programs on bus lines, providing transportation vouchers and offering services in proximity to related programs such as AA, help keep women in recovery and motivated to continue their journey of healing.

Access to Health Care:

Women with mental health and substance abuse/addiction problems have higher rates of co-occurring physical health problems, including sexually transmitted diseases, reproductive problems and general health concerns, and they need consistent access to quality health care (Grella, 1996). Primary care providers who treat women of color should be part of community advocacy and treatment teams, providing and receiving training and technical assistance on key issues in substance abuse/addiction and mental health treatment and recovery.

V. Action Steps

Now is the time for action! This publication was developed to motivate community action. New and existing coalitions need to work together to increase awareness about the prevention, intervention and treatment needs of women of color, and work across systems in local communities to increase access to, and improve the quality of, prevention interventions and treatment services for women of color.

Addressing issues of gender and cultural competence is not easy — it makes people uncomfortable and can challenge long held personal beliefs and community norms. But action on this information is critical — understanding the issues discussed in this paper merely set the stage. Coalitions and community work groups will find both profound challenges and great satisfaction in addressing the treatment needs of women of color.

Be sure that <u>appropriate</u> services are available and known. In some communities it will take time to design and fund programs that address the multiple treatment needs of women of color. Coordination of existing services and sharing information with other family-oriented service providers and community programs can strengthen and enhance the quality of care dramatically and quickly.

Market services wisely. Having treatment services available is not effective if these services are unknown in and to the community they serve. Information needs to be available in places where women in need and their families will see them, and formatted in ways that encourage access. Faith communities, youth organizations and other social service providers can be excellent resources for marketing outreach.

Educate the public and the stakeholders. Adopt an aggressive strategy to make the needs of these women known to the general public. Promote the many faces of recovery. Because public perception of women with mental health and addiction issues can be very negative, be

"Having to go to various places for different services is really hard, especially when you have kids and you have to get on the bus and you've got to be somewhere at a certain time and you're tired.

It made a real difference to go to my treatment program and have everything I needed. I had parenting training, family therapy, mental health therapy — in group and individually. I also had alcohol and drug sessions. My children played a big role in my recovery. And I am glad they have had this attention from the treatment center now. I hope that they will not follow in my footsteps." (SAMHSA News, 1999)

From a woman in recovery for 17 months, now clean and sober, caring for all of her children at home and serving as a consumer advisor to her treatment agency.

She was formerly homeless, addicted to cocaine and heroin, and facing the permanent loss of her five children and prison time for felony narcotics distribution.

sure that their stories and their strengths are emphasized.

Do not assume that the stakeholders understand all of the needs and issues. Many believe that the services being provided are adequate. They need to hear about specific gaps and barriers and be shown how more effective treatment is also cost-effective in other systems. Include stakeholders outside of the usual membership of mental health or substance abuse/addiction coalitions, such as local health clinics, community business leaders, faith community leaders, law enforcement and criminal justice personnel and community housing development organizations.

Outreach is key. The stigma that women who have mental health and drug abuse issues face is formidable. They need to be invited repeatedly by people whom they believe are credible and trustworthy. They need to see treatment and recovery as something that they can relate to — and succeed at!

Address myths and misconceptions up front and often. There are many misconceptions about women of color that suffer from addiction and/or mental illness. There are also many misconceptions within ethnic communities about mental health and substance abuse/addiction issues. All of these misconceptions need to be named and addressed directly, in multiple settings in the community.

The faces and voices of people of similar culture, race and background are critical. Hopeful messages to women and their families have to penetrate a great deal of noise and competing messages. There need to be role models and mentors in communities that convey a sense of leadership and possibility.

Involving consumers and family members is very important. They know what and where the major barriers to treatment and recovery are. They know which programs offer meaningful services — and which don't! People in recovery, their friends and their families can make excellent and insightful outreach volunteers.

Prevention must be targeted to high-risk groups. Children of parents with mental health and substance abuse problems are known to be at increased risk for an array of psycho-social problems. It is critical to get culturally sensitive and appropriate prevention messages into the community, targeted to families, young children and adolescents who are at increased risk for mental illness or substance abuse/addiction.

Community Call to Action:

It is unnecessary and inexcusable that women of color who suffer from mental health problems, substance abuse/addiction and co-occurring disorders are often unable to access appropriate treatment and prevention services in their communities. The stigma, fragmentation of services and system gridlock are unacceptable.

The information and stories in this background paper are only as useful as they serve to motivate communities to action. Community assessments, media campaigns and coalition meetings need to be outcome based. Policy and funding should respond to need, and providers must be motivated to work together to break old barriers and provide effective services.

The ultimate success of these efforts will be measured by the healing experiences of women who can share the joys and struggles of recovery and contribute to the health of their families and communities. Those in leadership roles must make a commitment to guarantee that sustained prevention and treatment services become more accessible to women of color, that stigma about mental illness and substance abuse/addiction are reduced, and community-based services are provided with gender, race and cultural sensitivity and competency.

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Web-Based Resources

National Mental Health Association — www.nmha.org

Center for Mental Health Services/Knowledge Exchange Network — www.mentalhealth.org

Substance Abuse and Mental Health Services Administration/
National Clearinghouse on Alcohol and Drug Information — www.health.org

National Alliance for Hispanic Health — www.hispanichealth.org

National Association for Children of Alcoholics — www.nacoa.net

Office of Minority Health Resource Center — www.omhrc.gov

National Institute on Drug Abuse — www.drugabuse.gov

National Institute of Mental Health — www.nih.nimh.gov

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